Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

New issues/stressors/extraordinary events presented today: None reported

Explanation: Patient was seen in MHP's office for her HCR submitted 5/17/22, received/screened 5/18/22 (routine), stating "I would like to speak with Ms. Martinez, Thanks in advance." During session, patient detailed traumatic events that she experienced as a child. She discussed her current charge and she processed her thoughts on her progress. Patient acknowledged having interpersonally exploitative traits and stated that she has tried to use them to her advantage. She discussed her upbringing in foster care and being separated from her siblings. Patient said that she would be open to participating in a mental health group should the opportunity arise. She expressed interest in being part of a mental health group focused on the LGBTQ population.

Goals, Objectives, and Interventions Addressed Today

Interventions/Methods Provided:
Practiced active listening while patient discussed her past trauma.
Inquired about patient's coping mechanisms and how she continues utilizing make up as a coping skill.
Encouraged patient to continue being proactive in her mental health treatment.
Praised patient for being self reflective and processing her emotions.
Response to Interventions/Progress Toward Goals and Objectives:
Patient remained cooperative and respectful throughout the session. she was receptive to feedback given by MHP.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		05/24/2022	05/24/2022	No				
Property	Denies		05/24/2022	05/24/2022	No				
Homicide	Denies		05/24/2022	05/24/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 70
Date: 07/01/2021.

Highest GAF: 70
Date: 05/03/2021.

Plan and Additional Information

Date	Order Description
08/22/2022	MHP follow-up for MH Monitoring

SIGNATURES

Staff: Signed by Leticia Martinez-Mateos, MSW, LSW on 05/24/2022

Behavioral Health Billing

Start time: 10:05 AM
End time: 10:55 AM
Duration: 00 hours, 50 minutes
Modifier: N/A

Document generated by: Leticia Martinez-Mateos 05/24/2022 04:20 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	05/07/2022 12:15 PM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: FER needed

Nurse Protocols:

Review/Comments
Patient smokes 16.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 2 tablet by oral route every day	N		
Proventil HFA 90 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 4 - 6 hours as needed	Y		
spironolactone 100 mg tablet	take 1 tablet by oral route every day	N		
Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N		

General Comments

FERS submitted for Estradiol and Spironolactone
FERS approved per Dr Wilks

Document generated by: Shannon S. McCord, LPN 06/16/2022 12:17 PM

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Indiana Government Center South
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 05/05/2022 10:34 AM
VISIT TYPE: Provider Visit

Established patient

Clinic	Additional	Enroll Date	Last Visit Date	Dis-enroll Date	Dis-enroll Reason
Asthma		01/14/2020		05/05/2022	
Asthma		04/08/2020		05/05/2022	

The following conditions were addressed during this chronic care visit:
Asthma
Other

History of Present Illness:

1. Gender dysphoria
   She stated tolerating estradiol well, budding and is a b cup.
2. Hyperlipidemia
   Risk factors include sedentary life style. Additional information: stated do not like to take medications but after discussion about high cholesterol agreed.
3. asthma
   The initial visit date was 02/12/2008. Symptoms of asthma began in 1984. Additional information: pt stated had asthma as a kid and stated has not used an inhaler in years and has been stable without one and does not have a proair on hand or want one. She feels do not need to be on CCC for athma anymore.
4. seiures
   she stated all the seizure medications offered on formulary are intolerable and do not want to take any medication for seizures. She reports no seizures awake from sleep like used to, cellmate may see occassional jerking in her sleep.

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Gender identity disorder of adulthood	06/17/2020	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot

Borderline personality disorder	05/04/2010	Y	MD. Onset date 02/19/2015. Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.
Recurrent major depressive episodes, mild	10/21/2019	N	

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

Allergies

Ingredient	Reaction	Medication Name	Comment
IBUPROFEN	Rash		
PENICILLINS	Rash		
CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results

Review of Systems

System	Neg/Pos	Details
Respiratory	Negative	Dyspnea.
Cardio	Negative	Chest pain and edema.
GI	Negative	Abdominal pain.

Vital Signs

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
11:12 AM	215.0		97.522			

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
11:12 AM	140/83					

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
11:12 AM	97.30	36.3		93		16

Pulse Oximetry/FIO2

RICHARDSON, JONATHAN 127630 [redacted] 05/05/2022 10:34 AM 257/291

Time	Pulse Ox-(Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
11:12 AM	98								

Measured By

Time	Measured by
11:12 AM	Vernon L Osburn, NP

Physical Exam

Exam	Findings	Details
Respiratory	Normal	Auscultation - Normal.
Cardiovascular	Normal	Heart rate - Regular rate. Rhythm - Regular. Heart sounds - Normal S1, Normal S2. Murmurs - None. Extremities - No edema.
Abdomen	Normal	No abdominal tenderness.
Extremity	Normal	No edema.

Suicide Risk Screening

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Asthma (493).
	Patient Plan	The patient verbalized an understanding of the plan.
	Provider Plan	consider peak flow at next visit and if acceptable range consider discharge from CCC for this dx as been stable w/o inhaler
2.	Assessment	Epilepsy (345).
	Patient Plan	The patient verbalized an understanding of the plan.
	Provider Plan	At this time pt is not ope to being on anti-seizure medications but if seizures recur may consider EEG and/or treatment

[redacted] Status PRN Reason [redacted]

Osburn, Vernon L 05/05/2022 11:21 AM

Document generated by: Vernon L Osburn, NP 05/05/2022 11:21 AM

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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 04/26/2022 6:37 AM
VISIT TYPE: Onsite Consult

INDIVIDUALIZED ACTION PLAN

Program name:
Admission date: 06/09/2016
Effective date of initial IAP:
Next review date: 10/27/2022

GOALS, OBJECTIVES AND INTERVENTIONS

Goal 3: Depressive symptoms do not impair daily functioning (continued)

Target date: 10/27/2022
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

Assessed need: Depression

Individual's strength/skills: {local.txt_stengths}

Potential barriers: {local.txt_barriers}

- Objective 1: Identifies negative thinking supporting depression (continued)
Start date: 06/30/2012
Target date: 10/27/2022
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: LGBTQ group
Modality: Group therapy Frequency: prn Type of provider: MHP

- Objective 2: Verbalizes increased feelings of self worth (continued)
Start date: 06/30/2012
Target date: 10/27/2022
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 03/07/2017)

-- Intervention 2: LGBTQ Group
Modality: Group therapy Frequency: prn Type of provider: MHP

Goal 4: Mismatch between assigned gender and gender identity no longer causes marked distress. (continued)

Start date: 07/22/2019
Target date: 10/27/2022

Assessed need: Evaluation for gender dysphoria

Individual's strength/skills: {local.txt_stengths}

Potential barriers: {local.txt_barriers}

- Objective 1: Identify ways in which gender identity leads to distress, exacerbates symptoms of depression, and contributes to other concerns such as irritability and self-destructive behavior. (continued)
Start date: 08/27/2020
Target date: 10/27/2022
Adjusted target date: (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: Person-centered, supportive, solution-focused interventions. LGBTQ Group
Modality: Group therapy Frequency: prn Type of provider: Psychologist

TRANSITION/DISCHARGE CRITERIA

Discharge plan:
4/26/22: TP updated to reflect group therapy needs.

8/23/21: Patient Autumn (Richardson) was seen for her 90 day routine monitoring and TPR. She denied significant mental health concerns, but acknowledged symptoms of grief over her two best friends being moved to another facility. She described being grateful to them for accepting who she is. She will continue to be monitored every 90 days.

8/27/20 - Richardson has been diagnosed with gender dysphoria and started hormone therapy. She has shown an improvement in mood, irritability, and interpersonal relatedness. An overarching goal for the next treatment period will be to continue to explore and grow into her role living as a woman.

Individual has participated in the development of this plan:
Yes

Others participated in the development of this plan:
No

SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 04/27/2022

Document generated by: Leticia Martinez Mateos 04/27/2022 06:59 AM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	04/26/2022 6:37 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

HCR#: 278077

Start time: 10AM

MENTAL STATUS EXAM

GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full
Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits

Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: Patient was seen in MHP's office for her HCR submitted 4/20/22, received/screened 4/22/22 (routine), stating "I would like to see Ms. Martinez". During session, patient acknowledged issues with the LGBTQ community as she stated that she has been experiencing an increase in harassment in her unit. Patient acknowledged that she has been applying makeup in the bathroom as she has been embracing her femininity. Meanwhile, other incarcerated individuals have been writing the word "fag" in the bathroom she uses. Patient denied knowing who specifically is writing these words. She stated that she has been overcoming this harassment by continuing to use makeup as her therapeutic outlet. She expressed pride in herself and acknowledged her strengths.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Identifies negative thinking supporting depression

Interventions/Methods Provided:
MHP utilized active listening while patient discussed her current barriers.
Provided feedback regarding her coping strategies and praised her for utilizing makeup as a therapeutic outlet.
Encouraged patient to continue practicing assertiveness.
Spoke with patient regarding joining an LGBTQ mental health group.
Response to Interventions/Progress Toward Goals and Objectives:
Patient remained cooperative and respectful throughout the session. She was receptive to feedback given by MHP.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		04/26/2022	04/26/2022	No				
Property	Denies		04/26/2022	04/26/2022	No				
Homicide	Denies		04/26/2022	04/26/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 70
Date: 07/01/2021.

Highest GAF: 70
Date: 05/03/2021.

Plan and Additional Information

Date	Order Description
07/25/2022	MHP follow-up for MH Monitoring

Plan/Additional Information:
Patient will be signed up for an LGBTQ mental health group PRN.

SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 04/27/2022

Behavioral Health Billing

Start time: 10AM
End time: 10:30AM
Modifier: N/A

Document generated by: Leticia Martinez Mateos 04/27/2022 06:53 AM

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SPECIAL NEEDS / URGENT ORDERS

SITE: CIC

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Division of Medical and Clinical Healthcare Services
Indiana Government Center South
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DOB: [redacted]
DOC#: 127630
DATE: 04/15/2022 11:09 AM
DOCUMENT GENERATED BY: Abiola Amusan, RN

Classification Orders

Order	Reason	Status	Start	End
Bottom bunk	RUE DEFORMITY	ordered	04/06/2022	10/06/2022
laying from work only		ordered	04/15/2022	04/17/2022

Indiana Government Center South
302 W. Washington Street
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NAME: RICHARDSON, JONATHAN
NUMBER: 127630
D.O.B: [redacted]

State of Indiana
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Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC #: 127630
DATE: 04/15/2022 11:09 AM
VISIT TYPE: Nurse Visit

Nurse Visit

Reason for visit: Abdominal pain

Statement of complaint (in patient's words): Frequent stooling over 24hrs

Vital Signs

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
11:13 AM	226.5		102.739			

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
11:13 AM	117/85					

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
11:13 AM	97.30	36.3		82		18

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
11:13 AM	98		RA						

Measured By

Time	Measured by
11:13 AM	Jodean Ayres, RN

Nurse Protocols:

EMERGENCY NURSING ABDOMINAL PAIN

Objective:

Distress	no acute distress
Orientation	alert
Skin exam	warm
Abdomen Exam	
Auscultation	Bowel sounds present.
Palpation	soft non-tender

Assessment: Abdominal pain

The following nursing interventions were completed

Medication allergies reviewed; pregnancy ruled out

Patient education provided

Follow-up:

Sick call if symptoms do not subside or become worse

Review/Comments
Patient smokes 16.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		
Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	Return to Housing Unit				
ordered	laying from work only				04/17/2022

General Comments

He complains of abdominal pain with frequent stooling over 24hrs, not in obvious distress at the moment, educated on importance of hand hygiene and to return to NSC if condition changes. Lay of from work given from work (kitchen) till sunday.

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	04/13/2022 9:34 AM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Med Renewal

Nurse Protocols:

Review/Comments
Patient smokes 16.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		
Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N		

General Comments

CC Rx Renewal

Document generated by: Shannon S. McCord, LPN 04/13/2022 09:35 AM

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SPECIAL NEEDS / URGENT ORDERS

SITE: CIC

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Department of Correction

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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DOB: [redacted]
DOC#: 127630
DATE: 04/06/2022 1:21 PM
DOCUMENT GENERATED BY: Tina Collins, RN

Classification Orders

Order	Reason	Status	Start	End
Bottom bunk	RUE DEFORMITY	ordered	04/06/2022	10/06/2022

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NAME: RICHARDSON, JONATHAN
NUMBER: 127630
D.O.B : [redacted]

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	04/06/2022 1:21 PM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Special Needs Order

Nurse Protocols:

Review/Comments
Patient smokes 16.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		
Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	Bottom bunk				10/06/2022

General Comments

BBP DUE TO R HAND MISSING 2 DIGITS - THUMB AND INDEX FINGER

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	03/31/2022 1:34 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

HCR#: 10446

Start time: 10AM

MENTAL STATUS EXAM

GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Mood: Depressed
Affect: Constricted
Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average

Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Explanation: Patient was seen for her HCR submitted 3/21/22, received/screened 3/24/22 (routine), stating " I would like to see Ms. Martinez". During session, patient processed her childhood trauma and current prejudices that she has been exposed to. Patient discussed being a survivor and moving away from the victim mentality. She described her strengths and acknowledged that her experiences have made her stronger and more capable. Patient stated that she perceives one of her strengths to be her vulnerability but she does not often get to practice it due to her prison environment.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Identifies negative thinking supporting depression

Interventions/Methods Provided:
Actively listened to patient as he described his barriers.
Encouraged patient to continue practicing recognizing her strengths.
Inquired about patient's progress in the last two months.
Validated patient's thoughts, feelings and experiences.
Response to Interventions/Progress Toward Goals and Objectives:
Patient remained cooperative and respectful throughout the session. He was receptive to feedback given by MHP.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		03/31/2022	03/31/2022	No				
Property	Denies		03/31/2022	03/31/2022	No				
Homicide	Denies		03/31/2022	03/31/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 70
Date: 07/01/2021.

Highest GAF: 70
Date: 05/03/2021.

Plan and Additional Information

Date	Order Description
06/29/2022	MHP follow-up for MH Monitoring

SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 04/01/2022

Behavioral Health Billing

Start time: 10AM
End time: 10:50AM
Modifier: N/A

Document generated by: Leticia Martinez Mateos 04/01/2022 01:43 PM

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State of Indiana
Department of Correction

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302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	03/02/2022 3:05 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

HCR#: 278753

Start time: 1pm

MENTAL STATUS EXAM

GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full
Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits

Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information
New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: Patient was seen in MHP's office for his HCR submitted 2/27/22, received/screened 2/28/22 (routine), stating "I would like to speak with Ms. Martinez, thanks in advance". During session, patient spoke about a recent incident in which he was called a "fag" by another offender. Patient stated he reported it to staff. She acknowledged that she has traits of being "manipulative" and spoke about those behavior patterns.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Depressive symptoms do not impair daily functioning	Identifies negative thinking supporting depression

Interventions/Methods Provided:
Actively listened to patient as she spoke about her "manipulative" traits.
Praised patient for her resiliency.
Challenged patient's belief that she is manipulative.
Inquired bout her coping skills and strengths.
Response to Interventions/Progress Toward Goals and Objectives:
Patient remained cooperative and respectful throughout the session. She was receptive to feedback given by MHP.

Current Assessment
Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment
CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		03/02/2022	03/02/2022	No				
Property	Denies		03/02/2022	03/02/2022	No				
Homicide	Denies		03/02/2022	03/02/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 70
Date: 07/01/2021.

Highest GAF: 70
Date: 05/03/2021.

Plan and Additional Information

Date	Order Description
05/31/2022	MHP follow-up for MH monitoring

SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 03/02/2022

Behavioral Health Billing

Start time: 1pm
End time: 1:45pm
Modifier: N/A

Document generated by: Leticia Martinez Mateos 03/02/2022 03:20 PM

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Division of Medical and Clinical Healthcare Services
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 02/08/2022 01:55 PM
VISIT TYPE: Provider Visit

Established patient

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Gender identity disorder of adulthood	06/17/2020	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.
Recurrent major depressive episodes, mild	10/21/2019	N		

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

Allergies

Ingredient	Reaction	Medication Name	Comment
PENICILLINS	Rash		
IBUPROFEN	Rash		

CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results

Review of Systems

System	Neg/Pos	Details
Constitutional	Negative	Chills, fatigue, fever, malaise, night sweats, weight gain and weight loss.
ENMT	Negative	Ear drainage, hearing loss, nasal drainage, otalgia, sinus pressure and sore throat.
Eyes	Negative	Eye discharge, eye pain and vision changes.
Respiratory	Negative	Chronic cough, cough, dyspnea, known TB exposure and wheezing.
Cardio	Negative	Chest pain, claudication, edema and irregular heartbeat/palpitations.
GI	Negative	Abdominal pain, blood in stool, change in stool pattern, constipation, decreased appetite, diarrhea, heartburn, nausea and vomiting.
GU	Negative	Dribbling, dysuria, erectile dysfunction, hematuria, polyuria, slow stream, urinary frequency, urinary incontinence and urinary retention.
Endocrine	Negative	Cold intolerance, heat intolerance, polydipsia and polyphagia.
Neuro	Negative	Dizziness, extremity weakness, gait disturbance, headache, memory impairment, numbness in extremity, seizures and tremors.
Psych	Negative	Anxiety, depression and insomnia.
Integumentary	Negative	Brittle hair, brittle nails, change in shape/size of mole(s), hair loss, hirsutism, hives, pruritus, rash and skin lesion.
MS	Positive	Joint pain.
MS	Negative	Back pain, joint swelling, muscle weakness and neck pain.
Hema/Lymph	Negative	Easy bleeding, easy bruising and lymphadenopathy.
Allergic/Immuno	Negative	Contact allergy, environmental allergies, food allergies and seasonal allergies.
Reproductive	Negative	Penile discharge and sexual dysfunction.

All other review of systems are negative.

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
2:04 PM	5.0	11.0		02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
2:04 PM	231.0		104.780	dressed with shoes	32.21	2.29

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
2:04 PM	120/78	sitting	left	arm	manual	adult

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
2:04 PM	97.70	36.5	temporal	82	regular	18

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
2:04 PM	97		RA						

Measured By

Time	Measured by
2:04 PM	Elizabeth A. Holloway, MHC

Physical Exam

Exam	Findings	Details
General Exam	Comments	+Finkelstein's on L
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal. Pupil - Right: Normal.
Nose/Mouth/Throat	Normal	Oropharynx - Normal.
Neck Exam	Normal	Inspection - Normal.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Capillary refill - Less than 2 seconds.
Abdomen	Normal	Inspection - Normal. Auscultation - Normal. No abdominal tenderness. No hepatic enlargement. No spleen enlargement. No hernia.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect. Normal insight. Normal judgment.

Suicide Risk Screening

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Carpal tunnel syndrome (354.0), left.
	Patient Plan	Brace Prednisone Tylenol
	Provider Plan	The patient verbalized an understanding of the plan.
	Plan Orders	splint/brace - wrist on 02/08/2022.

Labs

Date Ordered	Status	Test Status	Description	Order#	Provider	Test Location
02/08/2022 09:54 AM	Ordered	Pending	COMPREHENSIVE METABOLIC PANEL / CBC WITH DIFF / LIPID (CARDIAC) PANEL(INCL CHOLESTEROL, TRIG, HDL, LDL) / URINALYSIS / TESTOSTERONE, TOTAL / ESTRADIOL / PROLACTIN	1146786 8	Jones, John	CIC

Medications *(Added, Continued or Stopped this visit)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
12/17/2021	estradiol 2 mg	take 1 tablet by oral route	N		FER submitted	06/14/2022

RICHARDSON, JONATHAN 127630[redacted] 02/08/2022 01:55 PM 283/291

	tablet	every day			
02/08/2022	prednisone 10 mg tablet	Taper 6/5/4/3/2/1.	N	KOP	02/13/2022
09/27/2021	Proventil HFA 90 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 4 - 6 hours as needed	Y	DO NOT SEND - MAX REFILL ONCE Q 3-4M	03/25/2022
10/21/2021	spironolactone 50 mg tablet	take 1 tablet by oral route every day	N	KOP	04/18/2022
02/08/2022	Tylenol Extra Strength 500 mg tablet	take 1 tablet by oral route every 8 hours as needed	N	KOP	05/08/2022

Provider:
Jones, John 02/08/2022 2:04 PM
Document generated by: Elizabeth A. Holloway, MHC 02/08/2022 02:04 PM

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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC #: 127630
DATE: 02/01/2022 11:53 AM
VISIT TYPE: Nurse Visit

Nurse Visit

Reason for visit: Numbness
HCR#: 11025

Statement of complaint (in patient's words): "Numbness in left hand"

Vital Signs

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
11:55 AM	213.0		96.615	dressed with shoes		

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
11:55 AM	128/82	sitting	left	arm	manual	adult

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
11:55 AM	97.50	36.4		97	regular	18

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
11:55 AM	97		RA			21			

Measured By

Time	Measured by
11:55 AM	Jodean Ayres, RN

Nurse Protocols:
MUSCULOSKELETAL

Subjective:
Date of Onset: 02/01/2022.
Previous history? Yes.
Recent injury? No.
Pain? Yes. Comments: Pins and needles feeling
Objective:
Examination of Left hand.
Tenderness? No.
Palpable distal pulses? Yes.
Pain with movement? No.
Sensation intact? No.
Spasms? No.
Range of motion (WNL)? Yes.
Weakness? Yes.
Discoloration? No.
Warm to touch? Yes.
Tingling? Yes.
Gait (WNL)? Yes.
Numbness? Yes.
Swelling? No.

Bowel & Bladder Function
N/A to complaint (no complaints of back pain).

Urine dipstick?: Not indicated.

Assessment:
Alteration in comfort
Related to: strain/sprain.

Review/Comments
Patient smokes 16.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
estradiol 2 mg tablet	take 1 tablet by oral route every day	N		
Proventil HFA 90 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 4 - 6 hours as needed	Y		
spironolactone 50 mg tablet	take 1 tablet by oral route every day	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	Referred to provider - condition not responding to protocol	Routine			
completed	Patient education provided				
completed	Sick call if symptoms do not subside or become more severe				

General Comments

39yr old male presents to medical from the kitchen with complaints of having weakness and numbness in his left hand. Pt reports having issue all the time with periods of weakness / numbness then it returns to normal. Pt has ROM in hand / fingers. Pins and needles feeling. He reports at this time the numbness is lasting longer. Pt refer to MD for assessment.

Education	Date Provided	Provided By
Patient education provided	02/01/2022	Jodean Ayres, RN

Document generated by: Jodean Ayres, RN 02/01/2022 12:03 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	01/24/2022 9:09 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

HCR#: 12150

Start time: 10:30AM

MENTAL STATUS EXAM

GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full
Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits

Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: Patient was seen in MHP's office for his HCR submitted 1/3/22, received/screened 1/4/22 (routine), stating "I would like to see Ms. Martinez, please." During session, patient stated that she has been trying to "work on" her femininity. She described trying to make her voice sound more high pitched as her natural voice is deeper. She stated that she looks forward to being released from prison so that she may continue her physical transition into womanhood. She described being more comfortable in her own skin and acknowledged that she feels less afraid of showing her feminine side.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Mismatch between assigned gender and gender identity no longer causes marked distress.	Identify ways in which gender identity leads to distress, exacerbates symptoms of depression, and contributes to other concerns such as irritability and self-destructive behavior.

Interventions/Methods Provided:
Practiced active listening as patient discussed her coping strategies
Validated her thoughts and emotions given the transition she is currently making
Developed positive affirmations to remind patient of her strengths.
Response to Interventions/Progress Toward Goals and Objectives:
Patient remained cooperative and respectful throughout the session. She was receptive to feedback given by MHP.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		01/24/2022	01/24/2022	No				
Property	Denies		01/24/2022	01/24/2022	No				
Homicide	Denies		01/24/2022	01/24/2022	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 70
Date: 07/01/2021.

Highest GAF: 70
Date: 05/03/2021.

Plan and Additional Information

Date	Order Description
04/24/2022	MHP follow-up for MH Monitoring

SIGNATURES

Staff: Signed by Leticia Martinez Mateos, MSW, LSW on 01/26/2022

Behavioral Health Billing

Start time: 10:30AM
End time: 10:55AM
Modifier: N/A

Document generated by: Leticia Martinez Mateos 01/26/2022 03:28 PM

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